Prescription	Drug name (Drug Concentration(DC))	Daily Dose (Recommended Dose)	Route	Frequency	Duration
- Analgesic	❑ Acetaminophen ○ (120 mg/5 ml) ○ (160 mg/5 ml)	(10-15 mg/kg)	Oral	○ OD (Once /day) ○ BID (Twice / day) ○ TID (Three / day) ○ QIT (Four / day)	3-5 days
	❑ Ibuprofen ○ (100 mg/5 ml)	(4-10 mg/kg)	Oral	○ PRN	

The dose calculated for analgesic are the daily recommended per dose whole day

M. Jamal

Prescription	Drug name (Drug Concentration(DC))	Daily Dose (Recommended Dose)	Route	Frequency	Duration
- Antibiotic	❑ Amoxicillin ○ (125 mg/5 ml) ○ (250 mg/5 ml)	(25-45 mg/kg/day)	Oral	○ OD (Once /day)	7-10 days
	❑ Augmentin ○ (156 mg/5 ml) ○ (312 mg/5 ml) ○ (457 mg/5 ml)	(25-45 mg/kg/day)	Oral	○ BID (Twice / day) ○ TID (Three / day)	
	❑ Azithromycin ○ (200 mg/5 ml)	(5-12 mg/kg) - Day 1 (5-6 mg/kg) - Daily for (2-5 days)	Oral	○ QIT (Four / day)	
	❑ Clindamycin ○ (75 mg/5 ml)	(8-20 mg/kg/day)	Oral		

Dose calculated for antibiotic are the daily recommended for the whole day (Divided on # of time)

M. Jamal

Dose Calculations = (Recommended dose) **mg/kg X** (Child weight) **kg** = (Dose in mg) **mg**

_____ mg/kg X _____ kg = _____ mg

Dose in ml = $\frac{\text{(Dose in mg) x 5ml}}{\text{(Drug strength (mg))}}$ = ____ ml

$\frac{(\text{_____}) \times 5ml}{(\text{_____})\ mg}$ = ____ ml

(Strength in mg) — (5 ml)

(Dose in mg) — (? ml)

(_____) — (5 ml)

(_____) — (? ml)

Recommended dose (Daily) = (Daily Dose in ml)

= _____ ml

KINGDOM OF SAUDI ARABIA
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المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك عبد العزيز
كلية طب الأسنان
ص.ب : ٨٠٢٠٠ جدة ٢١٥٨٩
☎ : ٦٤٠٣٤٤٣
برقياً : "جامعة عبدالعزيز"
تلكس : ٦٠١١٤١ كاوني إس جيه

15 kg child

PRESCRIPTION FORM

Patient Full Name: Pt X

Patient File Number: 000000X

Please state Drug Name, Strength, Form, Dose, Frequency and Period:

R/ - Amoxicillin + clavulanic 312mg/5 ml

5 ml Q 12h (BID) for 7 days (Option 1)

- Ibuprofen 100 mg/5 ml

5 ml Q 6h (QIT) PRN

Or

- Amoxicillin 125 mg/5 ml

5 ml Q 12h (BID) for 7 days (Option 2)

- Paracetamol 160 mg/5 ml

5 ml Q 6h (QIT) for 2 days

Doctor's Signature : _____

Doctor's Name : _____

Form # 059

Faculty of Dentistry

M. Jamal